Marlene H. Dortch
Commission Secretary
Office of the Secretary
Federal Communications Commission
445 12th Street, SW
Washington, DC 20554

Re: Rural Health Care Support Mechanism (WC Docket No. 02-60)

Dear Commission Secretary:

INTRODUCTION

The California Telehealth & Telemedicine Center's (CTTC) mission is to promote the use of new information and communication technologies in order to improve and expand access to health services and information, with a special focus on California's medically underserved communities. CTTC provides a central resource for interested parties throughout the state. CTTC, which is supported by The California Endowment, has funded approximately 100 grants in the state of California over the last three years totaling $7,500,000. Telecommunication is a major issue with nearly all of these grants and will expand to most every community in this state. Two of the major barriers to the success of telehealth and telemedicine are inaccessibility and sustainability of telecommunications. It is very important that the Federal Communications Commission (FCC or Commission) do whatever is possible to make telecommunications affordable to rural communities. This submittal covers the following seven areas:

1. **Eligible Rural Health Care Provider**
2. **Support for Internet Service**
3. **Calculation of Discounted Service**
4. **Streamlining the Application Process**

5. **Competitive Bidding**
6. **Partnership With Others**
7. **Fraud and Abuse**

We appreciate the opportunity to respond and, to this end, offer the following comments:

1. ELIGIBLE RURAL HEALTH CARE PROVIDER

Recommendation: Expand eligible providers, cover all health services provided by eligible providers, and use "non urbanized areas" as the definition of a rural area.

The issue of eligibility in rural health care has three subparts or components. First, present regulations, as established by the Commission, disallow support for many legitimate health care services. Secondly, the definition of "rural" poses another significant dilemma. Thirdly, the FCC has simply applied too many restrictions on the types of services eligible for health care. There is confusion over "eligible provider" list and "eligible services" that needs to be addressed.

CTTC recommends that the FCC focus on the functionality of the service rather than the type of provider. Presently, if an eligible agency provides a service that is not considered eligible under FCC guidelines, that service cannot be subsidized. Dual-purpose agencies are not only very common in the rural setting but are a necessary condition for many areas to afford services. A rural hospital provides many services such as home health, skilled nursing, emergency, rural health clinic, hospice, as well as acute services. This restriction flies counter to what is necessary in most rural

communities. There needs to be a way to accommodate within the support mechanism these other vital services "eligible providers" make available.

Second is the issue that stems from the FCC's definition of "rural." Currently, the FCC uses as its definition of "rural" non-metropolitan statistical area (non-MSA) counties or areas that meet the Goldsmith Modification. We recommend that the FCC instead use the "non-urbanized area" as defined by the Bureau of Census. It would be consistent and appropriate to use this definition, which is used to define rural areas by two established federal rural health care programs, the Rural Health Clinic (P.L. 95-210), and the Swing Bed program (Section 904 of the 1980 OBRA). This definition is updated with the Census and is easy to use. All indications are that other federal agencies will adopt this definition in the future. Any definition that uses counties as the smallest unit does not work in a state like California, and many other Western States that have geographically very large counties. California's San Bernardino County is the largest county in the United States (except Alaska), and is larger than several individual states. This county includes the city of San Bernardino in one corner of the county. The rest of the 20,000+ square mile county is rural, frontier, desert -- anything but urban -- yet this county is an MSA. The Office of Management and Budget that sets the MSA/nonMSA county distinction recognizes this problem and never intended that this definition be used for anything other than research.

Thirdly, the FCC should expand the types of services that are considered "health care" in rural areas. The FCC can readily accomplish this by expanding the definition of eligible health care provider to include any rural, not-for-profit healthcare entity with a Medicare and/or Medicaid provider number. The Commission's current specific listing of eligible providers is only one interpretation of what Congress intended when it established the rural support mechanism. However, the current rules unreasonably deny support to many rural health care providers, including emergency medical services, nursing homes and long-term care facilities. Expanding the definition of eligible health care provider would foster the connectivity, which is crucial to health care in rural areas and would eliminate many of the current, apparently arbitrary, restrictions on provider eligibility.

2. SUPPORT OF INTERNET SERVICES

Recommendation: Application of a simple flat rate percentage with a cap rather than elimination of the program.

Internet access is vitally important to health care providers in rural areas. Although support for Internet access has been an underutilized component of this program to date, we do not support its elimination, which the FCC has identified as one possible alternative. We recommend instead that improvements be made to encourage broader use of this program.

The application process is too cumbersome and this deters many rural health care providers from applying for the subsidy. If the process were streamlined, we would anticipate a higher level of interest in this program. The Commission should make an effort to increase the availability of this service through elimination of unnecessary

paperwork rather than dropping the program altogether. Increased use of the rural subsidy mechanism for Internet access is unlikely to have a significant impact on the fund, given that $400,000,000 is available. Furthermore, discounts should be available for any type of Internet access: not just T1 or DSL but also services provided by cable companies, public utility boards, etc. Discounts should not be limited to the specific technologies available from local telcos where rural communities have other technologies available. The objective should be to deliver internet services to the locations of rural health care providers whenever it is feasible to do so. By expanding subsidies to cover alternative technologies, the program will provide an incentive for both the telcos and their competitors to extend broadband infrastructure into rural areas.

3. CALCULATION OF DISCOUNTED SERVICES

Recommendation: Change the rate comparison from the nearest city of 50,000 or more to the rate for the largest city in the state or an average rate of largest cities in the state, and eliminate the Maximum Allowable Distance (MAD).

Functionality should be the operative component to application of any subsidy. We agree with the Commission, "some less expensive urban services are unavailable at any price in rural areas." In terms of clinical efficacy, bandwidth is more important than technology application. The type of technology deployed is not a factor with the clinician and patient. Bandwidth up and down is the important factor and should be the focus of FCC regulations implementing Universal Service.

Furthermore, The Telecommunications Act of 1996 did not mandate a rate comparison to the nearest city of 50,000. This should be changed to consider the rate in the largest city in the state or average rate of the largest cities in the state.

The MAD should simply be eliminated. Eliminating MAD would gain greater flexibility in developing networks etc. It is also true that in remote areas MAD can actually have a negative affect. For example, a telecommunication provider knowing that the client will pay the same rate regardless may have some inclination to raise the price to whatever they believe they can get by with. Even though the intention was to prevent any one type of user from using an inordinate share, MAD actually sets a large barrier for the application of subsidies to rural areas.

4. STREAMLINING THE APPLICATION PROCESS

Recommendation:

- ***Establish a 2-step application process that first establishes eligibility and then considers the service request.***
- ***Telecommunications provider should invoice the provider the discounted rate upfront so that there is an incentive for them to submit their forms.***
- ***Allow for multi-year service requests or automatic renewal to reduce redundant paperwork.***
- ***The Commission should consider organizing a group of experts in this field and users, to develop specific suggestions and changes to simplify and improve the application process.***

The current application process must be fundamentally revamped and greatly simplified so the process itself is not a barrier to rural health care providers. One possible improvement would be to go back to the basics and set a two-step process. First establish eligibility with deadlines on everyone's turn around times. This would provide an up front screening process for an ineligible provider, thus ensuring that time and resources spent on the application is not wasted. The second step would be to request the service and would include clear mandated turnaround times laid out for all parties (applicant and telecommunications provider).

The billing process must also be improved. Currently, the telecommunications service provider submits an invoice to the rural health provider at the urban rate and the rural provider is fronting the difference until the application is approved. The telecommunications provider has no incentive to turn around the necessary paper work leaving the rural health care provider carrying the cost. Putting this burden on the rural health care providers is a strong deterrent to participation in the program. Mandated turnaround time on their paperwork is sine qua non for the telecommunication provider.

There are now a considerable number of individuals that have worked with the Universal Service program and, therefore, CTTC recommends that the Commission consider organizing a group of experts in this field, including those who have used the system over the years, to recommend specific ideas and procedures that would work for everyone.

5. COMPETITIVE BIDDING

Recommendation: Support the current system of competitive bidding but selection criteria should include issues such as available technical support and quality and should not be based on cost alone.

This issue may not be as transparent as other aspects of this program, and procuring the best bid on a service may not always result in the lowest cost of service. For example, the lowest bid may be from a telco that cannot provide the future expansion necessary. Also a telco may provide inadequate service requiring the end user to seek additional help that would otherwise be unnecessary. Many times there is only one provider in the rural community and where there is more than one, the rural health care provider has probably already chosen the least costly vendor. Also, in many cases, the rural health care provider has entered into multi-year contracts to reduce the rates. This, of course, is not allowed under the current regulations. Again another built in barrier to providing telecommunication services at an affordable price.

6. PARTNERSHIP WITH OTHERS

Recommendation: The FCC eligibility criteria should be flexible enough to provide incentives for designing efficient telecommunication systems.

Partnership – sharing local resources – is essential in most rural areas. There needs to be incentives for cost/line sharing in small communities. It is a waste to have separate T-1 circuits separately installed into the library, the school, and the hospital in a single community. A school-based health clinic program should be allowed access to discounts. In general, collaborative efforts including schools, libraries, and other appropriate entities should be encouraged.

7. FRAUD AND ABUSE

Recommendation: FCC allows a 5% variation in the actual support paid to rural health providers, and allow more flexibility in the overall program.

There is fluctuation of actual costs charged by telecommunication providers as taxes and added charges change. Rates negotiated by contract remain static, but actual charges change as the states' public utilities commissions adjust tariff rates. A user should not be required to submit new forms for every rate adjustment. Streamlining the process with fewer restrictions would help reduce much of this activity but should be complimented with oversight. More flexibility in decisions may result in fewer violations and less fraud and abuse. We would also recommend that FCC look to other agency's programs for suggested methods of addressing potential fraud.

CONCLUSION

The digital divide between rural and urban areas is increasing as telemedicine capabilities intensify rapidly in the urban settings. We commend Congress and FCC for their efforts to bring telecommunications to the rural area and hope that our comments are helpful. We appreciate the effort the Commission is making to streamline the Universal Service Program. Telecommunication is an essential component to the success of Telehealth and Telemedicine. Any improvement in this program will greatly assist CTTC in promoting Telehealth and Telemedicine so drastically necessary to the rural communities.

Sincerely,

Sharon Avery

Executive Director, California Telehealth & Telemedicine Center